ATTITUDES TOWARDS ADOLESCENT FRIENDLY HEALTH SERVICE PROVISION AMONG HEALTH WORKERS AT A PRIMARY HEALTH CARE CLINIC IN WINDHOEK, NAMIBIA

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Declaration

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Abstract

Health statistics on adolescents in Namibia indaicate high incidences of teenage unwanted pregnancies, unsafe abortions, baby dumping, maternal ill health, early marriages and STIs including HIV. These are indicators of underutilisation of adolescent friendly health services (AFHS) by adolescents as education on these problems are covered in it. Although Government has made some strides to esure implementation starts, there is a recognisable lack of its adoption by health workers. The aim of this study was to establish the reasons for the slow adoption of AFHS practices by health workers at Katutura Health Centre. A quantitative non-experimental cross-sectional descriprive research approach was used in this study. Evidence using both primary data collected in the field through self-administered semi-structured questionnaires (with both open and closed questions) and secondary data collected in the literature review was employed . A census of the entire population of health workers was prefered over sampling. A total of 56 health workers accepted to participate in the study and the questionnaire, 46 of which returned it within a stipulated three weeks data collection period. Descriptive statistics was utilised together with frequencies, mean and basic collection. Eighty two percent of the sample participated in the study of which 67% respondents were female and 33% were male. The majority of the respondents (78.3%) had tertiary education. The results indicated: AFHS were not known to the majority of health workers; there is slow adoption of AFHS; and the programme introduction could have been done better. Factors significantly associated with adoption of AFHS are knowledge of such services, sex, level of education, job position, work experience and effective implementation of the programme. A probability value of $p<0.05$ was adopted. The programme is well appreciated despite concerns of lack of training and proper implementation. Key recommendations were on staff recruitment, retention and training of health workers; creation of space for implementing AFHS and marketing the programme. The system is in place, what is left is to tighten some loose ends and programme is up and running.

Opsomming

Gesondheid statistieke oor die jeug in Namibië verwys na hoë voorkoms van ongewenste tiener swangerskappe en onveilige aborsies, weg gooi van babas, swak moederlike gesondheid, vroeë huwelike en seksueel oordraagbare siektes, insluitend MIV. Dit is aanwysers van die onderbenutting van jeug vriendelike gesondheidsdienste (AFHS) deur die jeug, as die onderwys op hierdie probleme gedek word. Hoewel die regering 'n paar implementerings begin het, is daar 'n beduidende gebrek van aanneming deur gesondheidswerkers. Die doel van hierdie studie was om die redes vas te stel vir die stadige aanvaarding van AFHS praktyke deur gesondheidswerkers by Katutura Gesondheids Sentrum. 'n Kwantitatiewe, nie-eksperimentele navorsingsbenadering is gebruik in hierdie studie. Bewyse uit beide primêre data wat ingesamel is in die veld deur middel van self-geadministreerde semi-gestruktureerde vraelyste (met beide oop en geslote vrae) en sekondêre data wat ingesamel is in die literatuuroorsig was gebruik. 'n Sensus van die hele bevolking van gesondheidswerkers is verkies in plaas van steekproefneming. 'n Totaal van 56 gesondheidswerkers het aanvaar om deel te neem aan die studie en die vraelys, waarvan 46 teruggedien is binne die vasgestelde tydperk van drie weke se data-invorderingstermyn. Beskrywende statistiek is gebruik saam met frekwensies, gemiddelde en basiese versameling. Tagtig en twee persent van die steekproef het deelgeneem aan die studie, waarvan 67% respondente vroulik en 33% manlik was. Die meerderheid van die respondente (78,3%) het tersiêre opleiding. Die resultate het aangedui: AFHS is nie bekend aan die meeste van gesondheidswerkers nie, en daar is stadige aanneming van AFHS; en die program inleiding kon beter gedoen gewees het. Faktore wat beduidend verband hou met die aanneming van AFHS is kennis van sodanige dienste, geslag, vlak van onderwys, werk posisie, werkervaring en doeltreffende implementering van die program. 'n Waarskynlikheid waarde van $p < 0,05$ is aangeneem. Die program is goed waardeer ten spyte van kommer aan 'n gebrek van opleiding en behoorlike implementering. Belangrikste aanbevelings was op die personeel werwing, behoud en die opleiding van gesondheidswerkers; skepping van ruimte vir die implementering van AFHS en bemarking van die program. Die stelsel is in plek, wat oorbly om gedoen te word, is om 'n paar los punte te versterk en die program is aan die gang.

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ACRONYMS

ACC	Adolescent Consultative Committees
AFHS	Adolescent Friendly Health Services
AIDS	Acquired Immunodeficiency Syndrome
ARVs	Antiretroviral drugs
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CRC	Convention of the right of Children
EN	Enrolled Nurse
FP	Family Planning
GBV	Gender-Based Violence
HDS	Health Development Survey
HIV	Human Immunodeficiency Virus
HSS	National HIV Sentinel Survey
HTC	HIV Testing and Counselling
IEC	Information Education Communication
IUD	Intra Uterine device
KHC	Katutura Health Centre
MDGs	Millenium Development Goals
MoHSS	Ministry of Health and Social Services (Namibia)
NDHS	Namibia Demographic and Health Survey
NDP	National Development Plan
NGOs	Non Governmental Organisations
NPC	National Planning Commission
NSF	National Strategic Framework for HIV and AIDS Response in Namibia
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmition
PrEP	Pre-Exposure Prophylaxis
RN	Registered Nurse
SRHR	Sexual and Reproductive Health Rights
STIs	Sexually Transmitted Infections
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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CHAPTER 1
INTRODUCTION

1.1 Background

The adoption of adolescent friendly health services services by health workers at Katutura Health Centre (KHC), a primary health care clinic in Windhoek, Namibia is placed in context. This is an important area in the health of adolescents that lack timely and effective adoption and implementation. The lack of adoption and timely implementation of any intervention leads of lack of utilisation of the service by its intended target audience. Most HIV and AIDS campaigns in Namibia are based on prevention through behaviour modification. The question is how prevention campaigns can become more effective given the existing sexual cultures and structural conditions that encourage risky sexual behaviour on Namibia. The evidence from past research shows some prevention campaign messages do not relate to existing sexual cultures and these messages are largely ignored hence the need to use strategies that work. Issues of adolescents' sexual reproductive health and gender equality needs have been recognised through the introduction of the "Adolescent Friendly Health Services (AFHS)" programmes, which are mainly for HIV and sexual and reproductive health and rights (SRHR). The ministry of health and social services (MoHSS) admits there is need for immediate modification of the implementation methodology so as to make the intervention useful (MoHSS, 2011).

Namibia has a youthful population, 40% of the population is under 18 years (UNICEF, 2011) and these young majorities face a number of problems: they become sexually active at a very tender age, while hardly using any protection against sexually transmitted infections (STIs) including HIV and pregnancies (MoHSS, 2011). Young girls in Namibia are reported to have sexual relations by men who are ten or more years older than them, intergenerational sex (UNICEF). The National Demographic and Health Survey (NDHS) has reported 3% of girls 15-17 years and 6% of girls 18-19 years had sex with a partner 10 or more years older which indicate high incidents of intergenerational sex (NDHS, 2008). Intergenerational sex is often transactional as the young girls will need financial support and gifts from these men (UNICEF, 2011). In a recent study among adolescent girls, it was found out that one third of the sexually active girls had received money or gifts in exchange for sex (UNICEF). While all women are also at more risk of HIV transmission that men and young women are at most risk mostly because their first/early sexual experience is often more traumatic, rough with a lot of tears and bleeding and these conditions are conducive for HIV transmission. The failure to use condoms is caused by a lack of access to them, which may also be caused by cultural and religious beliefs that young people cannot have sex before marriage. Teenage pregnancies are also high especially among girls 13-19 years. According to the

NDHS (2008) in 2006/7 one in seven girls aged 15-19 has already stated the child bearing process, with some already mothers (13%) and others already pregnant with their first child. Pregnancy leads to many other problems like STIs including HIV, school drop outs, high unemployment and poverty. In 2009 14% of girls in the country dropped out of school due to pregnancy (UNICEF). All these problems call for urgent action from government and other stakeholders and the introduction of the AFHS intervention is certainly a good start.

While the AFHS programme is obviously a good intervention that demonstrates government's effort in trying to keep the HIV prevalence among adolescents low, if health workers themselves, the catalysts of the intervention are not keen on taking it up or are working under conditions that are not supportive of the intervnetion, then the programme will remain rhetoric. The government is trying its best in setting an environment that enable the implemention of the programme, it is now up to the health workers to fully adopt and implement it well. Several surveys and studies have been conducted in and around the country to examine HIV awareness and risk behaviours and to gain more insight into which social factors increase vulnerability to infection. The different research reports (UNICEF, UNFPA) even from government (the joint rapid assessment on AFHS by MoHSS, UNFPA & UNICEF); it is apparent the pilot AFHS approach is not doing well. It is not being fully utilised by young people despite the importance. In addition a comprehensive review of this research has not yet been undertaken. The purpose of this study was to examine the adoption of the AFHS approach vis a vis the uptake of the service and then to establish why the adolescents are not utilising the service. The research question was therefore: What factors are associated with the adoption of adolescent friendly health service practices by health workers at Katutura Health Centre, Namibia?

1.2 Rationale

Governments in Sub-saharan Africa and their partners are focussed on solving the problems underlying HIV and AIDS. Attention is being paid to the SRHR of adolescents with regards to HIV prevention. There is a premise adolescents are not comfortable accessing SRHR and HIV services from public health institutions. Services they need are either not available or not well presented to them. There is an understanding that if AFHS are implemented well through Government support and vigorous marketing to adolescents and their parents/guardians, most of the problems they face will be greatly reduced. The importance the atitudes and expertise of health workers in implementing AFHS can not be over-emphasised. This paper focusses on getting opinions from health workers as a wealth of studies have

previously targeted adolescents themselves as the source of information. Health workers are central to the execution of effective AFHS.

1.3 Research Problem

Health statistics on adolescents show high incidences of teenage unwanted pregnancies, unsafe abortions, baby dumping, maternal ill health, mental health, early marriages, alcohol, drug and substance abuse and HIV (MoHSS, 2011). A high incidence of these problems may be an indicator of lack of or underutilisation of AFHS by adolescents because education, counselling and treatment of adolescents are part of the AFHS package. These problems faced by adolescents can be reduced greatly by an effective implementation of AFHS. While this age group has one of the lowest HIV prevalence its rate of increase in STIs including HIV needs to be curbed. There is also, a recognisable under implementation of AFHS by health workers and in return underutilisation of the service by adolescents in Namibia.

While the government is making an effort to provide AFHS actual implementation on the ground is a different issue. There are a number of reasons that may be causing this lack of adoption of AFHS. The health workers may be lacking the capacity to provide the service effectively, leading to them not implementing the package or the adolescents not utilising the service. The health facilities may lack the needed infrastructure to implement the AFHS programme for example private rooms to be used by adolescents and the service end up being unfriendly to adolescents. This may lead to lack of motivation by health workers and be deficient utilisation by adolescents. It may just be the attitude of health workers towards the adolescents coming for HIV and SRHR services that leads to the underutilisation. The government has, however, made of strides and efforts in the area of AFHS. They have developed the AFHS national standards that clearly stipulate the minimum package, the process of implementation and the roles and responsibilities. It has trained and oriented a number of health workers on the implementation of the service.

The reseach question was: What factors are associated with the adoption of adolescent friendly sexual and reproductive health service practices by health workers at Katutura Health Centre, Namibia?

1.4 Aim/ General Objective

The aim of this study was to establish the reasons why there is a slow adoption and implementation of the adolescent friendly health service practices by health workers in order to improve the adoption thereof and to contribute to the health seeking behaviours of adolescents.

1.4.1 Objectives of the Study

The objectives of the study are:

2. To determine the knowledge and understanding of the AFHS programme by health workers at Katutura Health Centre Namibia (KHC), Namibia.
3. To establish the factors that are associated with the slow adoption of adolescent friendly health practises by health workers at KHC, Namibia.
4. To evaluate the approach that the MoHSS is using to introduce and implement the AFHS programme to the health workers.
5. To recommend better approaches to introducing new programmes to health workers and to provide guidelines for interventions that increase the uptake of AFHS at public health institutions in Namibia.

1.5 Significance of the Study

This study will benefit the government to understand the factors that assist or hinder the adoption of AFHS through the sharing of the findings. It will also help them develop better approaches to introducing new initiatives like the AFHS programmes to health workers. The government will also understand how the health workers feel about new programmes particularly this AFHS initiative and how to have them implement the programme well. The MoHSS and other ministries such as education, youth and gender will also benefit as they will get guidelines and recommendations for effective interventions for adolescents. Having AFHS is a good intervention that shows particular concern for young people but the service needs to be managed in a manner that ensures intended beneficiaries utilise the services. Young people are future leaders and therefore their health needs need to be prioritised. Interventions targeted at young people are also important when done appropriately, they assist in the reduction and or eradication of HIV for future generations.

The adolescents themselves and the organisations working with them will also benefit in a number of ways. They will receive the support they need with a good service and their health seeking behaviour will also improve which will lead to their improved health. If adolescents effectively utilise the whole package of AFHS they will have all the information they need in order to make informed decisions and most importantly stay HIV negative or live positively. The formation of better adolescent programmes will encourage them to make use of this important service. The best approach to work with adolescents will also be established and this will benefit organisations working with and for adolescents.

1.6 Brief Research Methodology

This study was conducted at Katutura health centre (KHC) a public health clinic in Windhoek, Namibia. The clinic has about 62 health workers (only ones that interact with patients) in both the general and the ART clinics. A quantitative non-experimental research approach was used in this study. It was the best approach in investigating a new area (Christensen, Johnson & Turner, 2011). The goal of this study was to get an accurate picture of the situation of AFHS at Katutura Health Centre. This was a cross-sectional study where data was collected during a single and brief period of time (3 weeks). The entire population of 56 (ones that were available) health workers at KHC were surveyed using a questionnaire. Participants would either fill out the questionnaires on their own or they would be interviewd on them, about their attitudes, activities, opinions and beliefs (Christensen). A cross-sectional survey design was chosen because of its strengths in measuring attitudes, activities opinions and beliefs. In answering the research question the aim was to establish the attitudes, beliefs and opinions of health workers on the AFHS approach and on adolescents themselves. Three processes were used in the study, namely: collection of data, coding of data, and analysis of data (Glaser & Strauss, 1967).

A literature review of existing data, past research, documents and publications that discuss and interrogate the factors associated with the adoption of AFHS by health workers and HIV, SRHR and young people, particularly their health seeking behaviours vis a vis the use of AFHS was conducted. This review was instrumental in the conceptualisation of the research as well as in drawing together the background information critical to underpin the survey. Evidence using both primary data collected was employed in the field through self-administered questionnaires and secondary data collected in the literature review. A list was obtained of all KHC employees and a cross-section of respondents from the health workers working at the clinic was selected, that is, 22 nurses (both registered and enrolled), 7 medical doctors, 8 community counsellors, 4 pharmacy assistants, 1 Pharmacy Work Hand, 1 assistant radiographer, 3 Assistant clerks. A maximum of 56 KHC employees were reached.

Descriptive statistics was utilised together with frequencies, mean and basic collection. Data was entered on a statistical software packages, SPSS for analysis.

1.7 Limitations

Time constraints were a major factor in conducting this research. This was because of the delays the researcher experienced in getting approval to conduct the research from MoHSS and the Regional Office for health. This permission was sought end of October and November 2012 respectively and the data collection was to be finished in the same month. Facility challenges included getting time for the staff to fill in the questionnaire and other staff members being on leave. However, every effort was made to overcome these problems.

1.8 Outline of Chapters

This report has five chapters beginning with this background information as an introduction of the research topic and problem, AFHS.

The second chapter explored the literature around the adolescents and AFH sexual and reproductive health and rights. This section also summarised what previous researchers discovered around the research problem.

Chapter three will be the research methodology and it will describe how the survey will be done. It will also elaborate on the research philosophy, design and the methods, that is, the data collection procedures, instruments, data processing and analysis.

The fourth chapter will have the data presentation, analysis, interpretation and discussion.

The final chapter will summarise the study, conclude and give recommendations.

1.9 Conclusion

The study has been placed in context against the problem statement and formulated objectives. A roadmap was presented to guide the study in the diretion that will ultimately deliver a solution to the identified problem. The following chapter will explore the literature around the study topic from the country, the region and the international communities.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This literature review will be based on existing literature and findings around health workers' attitude towards the AFHS programme and the AFHS package itself. Government documents; policies, guidelines and training manuals will be analysed to look for evidence on the link between the utilisation of AFHS by adolescents and the service package. Past research around the theme will also be reviewed. This review is going to look at three subject matters namely, overview of HIV and AIDS; that is, what HIV/AIDS is, incidence and intensity in the world, in sub-Saharan Africa and Namibia; then the AFHS initiative, and then policies, that is, the legal framework around the subject matter. This section will also explore the health worker activities, attitudes, opinions and belifes towards AFHS to establish if these attitudes are linked to the low level uptake of the service and finally the adolescent health seeking behaviour.

2.2 Overview of HIV and AIDS

This section will give an overview of the impact of HIV and AIDS globally, in sub-Saharan region and in Namibia with special focus to aspects of the epidemic that affect adolescent health and development.

2.2.1 About HIV and AIDS

Human Immunodeficiency Virus (HIV) became a public concern from around 1980 although it is believed that it was there much earlier than that (Anderson, 2012). There is HIV 1 and 2 and these have many different sub types with HIV 1 subtype C being common in sub Saharan Africa and other heterosexual communities. HIV has some unique characteristics that enable it to overcome the immune system or antiretroviral drugs (ARVs). It mutates rapidly hence preventing scientists from getting a cure or vaccine. This is why the world is still grappling with the epidemic particularly Africa. HIV is transmitted through blood and body fluids like semen, vaginal secretions and breast milk from HIV positive people. The most risky way of getting HIV is receptive anal sex followed by receptive vaginal sex. The future of the HIV epidemic cannot be certain considering the way it is transmitted and prevented; these ways are mainly behaviour related and even though it is possible to change, it is not easy to achieve.

HIV can be prevented by a number of ways including abstinence, delaying sexual debut, being faithful to one uninfected partner and using condoms correctly and consistently. Addressing the drivers of the epidemic coupled with behaviour change programming will also help in improving the situation.

Antiretroviral treatment; from the UZUCSF 052 study results; can now also be used as prevention and this supports the effectiveness of ARVs in HIV prevention (UZUCSF, 2012). It is now known that people living with HIV (PLHIV) who are on treatment are likely to become non infectious reducing the chances of onward transmission. ARVs can also be used for Post Exposure Prophylaxis (PEP), Pre-Exposure Prophylaxis (PrEP), Prevention of Mother-to-Child Transmission (PMTCT) of HIV and in microbicides. If untreated HIV develops into aquired immunodeficiency syndrome (AIDS). The amount of HIV in the human body is measured by the viral load and tested using CD4 count cells. When the immune system continues to weaken, severe opportunistic infections are experienced and an AIDS diagnosis is given. This can be prevented by taking life prolonging drugs, ARVs.

2.2.2 Global and sub-Saharan Africa HIV Overview

According to the 2012 UNAIDS epi-update report, globally there were 34 million PLHIV at the end of 2011 (UNAIDS, 2012). An estimated 0.8% of adults aged 15-49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide (UNAIDS). The same report also estimates worldwide, the number of new infections is falling: the number of people (adults and children) acquiring HIV infection in 2011 was 20% lower than in 2001. By December 2010, about ten middle-low income countries including Botswana, Namibia and Rwanda achieved their universal access to ART (WHO, 2011). The number of children on ART in these countries also increased by 29% in the same years (WHO). This figure is still, however, very low compared to the number of children who need treatment.

However, despite these gains, sub-Saharan Africa accounted for 71% of the adults and children newly infected in 2011, underscoring the importance of continuing and strengthening HIV prevention efforts in the region. There are a number of driving factors that are either general or specific to regions, countries or cultures/tribes. The general drivers of the epidemic in sub Saharan Africa include concurrent sexual partnerships which are mostly multiple, low and inconsistent condom use and risk perception, intergenerational sex which is closely linked to transactional sex, gender inequality, harmful cultural practices, norms regarding sexual relations, migration, alcohol use, poverty and literacy levels. These problems are not yet all under control, while it is increasing, correct and consistent condom use is still needed so is the reduction of multiple sexual partnerships, transactional and intergenerational sex. The region is still grappling with these challenges and there is still a lot of work to be done.

2.2.3 HIV and AIDS in Namibia

Namibia has about 2.2 million and about 42% of this population is under 18 years (UNICEF, 2011). The country has a generalised and mature epidemic and HIV is generally transmitted through heterosexual contact (NPC, 2006). The first case of HIV was diagnosed in 1986 and the HIV prevalence rate continues to stabilise as is evident in the recent 2012 national HIV Sentinel Survey (HSS) report (MoHSS, 2012). According to the 2012 HSS report, the HIV prevalence rate is now 18.2%, a slight decrease from the 2010's 18.8%; the peak was 22% in 2002. The same report stated national HIV prevalence amongst 15-19 year old pregnant girls as standing at 5.4%; a slight decrease from the 6.6% of 2010 and currently the lowest HIV prevalence rate (MoHSS). In 2008/9 the HIV prevalence among the youth aged 15-24 was 31% (NSF, 2010) and 68% of these infections were among females (UNICEF).

Although the slight drop in the prevalence of the female adolescents aged 15-19 should be celebrated, more effort is still needed especially in reducing health challenges for adolescents particularly girls. There are a number of factors driving the epidemic in Namibia and these can be classified into biological; lack of male circumcision, behavioural, concurrent sexual partnerships which are sometimes multiple, inconsistent condom use, low HIV risk perception, alcohol abuse, intergenerational sex, transactional sex and social/structural; mobility and migration patterns and norms regarding sexual partnerships (MoHSS, 2009). Of these drivers, adolescents are mostly affected by all the behavioural factors and norms regarding sexual partnerships and these and more challenges they face shall be expanded in section 2.4.2 (adolescent health seeking behaviour).

2.3 The Adolescent Friendly Health Services (AFHS) Initiative

This section will discuss the AFHS initiative, local (Namibia), regional and international policies on children, adolescents and youth and the National standards for AFHS with special reference to the World Health Organisation (WHO) African strategy for adolescents. In this section, some important adolescent health challenges and their determinants.

2.3.1 Policies On and Related to Adolescents

According to UNICEF (2011) adolescent hood marks a period of transmission from childhood to adulthood and generally it is between 10-19 years. This age group needs a lot of support from parents, the community and health workers during this stage of sexual maturation and a lot of physical changes. Namibia's response to the impact of HIV and AIDS on children has been very progressive in many levels, particularly in policy development (UNICEF).

The country has set a strong enabling environment that protects the rights of children through the signing of a number of international conventions including the Convention of the right of Children (CRC), the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and the African Charter of Rights and Welfare of the Child (UNICEF, 2011). At home Namibia has its constitution, the national policy on HIV and AIDS which is committed to the involvement of children on relevant policies and asserts the need to protect children from sexual abuse and exploitation (UNICEF). Namibia also has the HIV and AIDS charter of rights of 2002, which specifically prohibits all discrimination against children orphaned by AIDS. The country is also signatory to the International Conference on Population and Development (ICPD, 1994) which recognises that family planning is a human right issue and launched a family planning policy in 1995 (MoHSS, 2008).

Namibia also has sector policies on children and HIV and these include the national policy on OVC of 2004 and this reaffirms the rights of OVC; the national policy on HIV and AIDS for the education sector of 2003 and this ensures the right to education for children affected by HIV and AIDS including in situations where they cannot pay school fees (UNICEF, 2011). There is also the education sector policy for pregnancy which deals with HIV information, counselling and school constitution for pregnant learners (UNICEF). Other general policies like the national gender policy, STI guidelines, PMTCT guidelines, the married persons' equality Act and the combating of rape, abortion Act, family planning Act, forced sterilisation policy, national plan of action for orphans and vulnerable children (OVC) among others also cater for children's rights and health.

The Reproductive Health (RH) policy (under review) and all the polices mentioned above and more work are government efforts to address the country's health, population and development programmes. They demonstrate the government's commitment to Namibia Vision 2030, which takes into consideration the Millennium Development Goals (MDGs) and the ICPD Programme of Action, (MoHSS, 2008). These policy frameworks help to set a good legal environment that is conducive for the implementation of children's programmes health. The government of Namibia, through their SRHR policy and through the National Strategic Framework for HIV and AIDS response in Namibia (NSF) recognised the importance of adopting HIV prevention strategies that are targeted for adolescents. This was because for many years, this group of people was regarded as a healthy and safe segment of the population and therefore have not received any priority for health related interventions despite the many health challenges that they are facing (MoHSS, 2011). The government then realised this was a serious problem considering the population of the country and that HIV is a huge threat to young people in the country (UNICEF, 2012).

The policy provides guidance to sexual and reproductive health services delivery including family planning in the country. The policy also promotes access to SRH for every Namibian, adolescents included, who needs and wants such services and that every client should have good quality of care, including choice.

However, despite Namibia having many good policies and guidelines in different issues around SRHR and HIV; many challenges to improvement of people's qualities of lives remain, including the effective implementation, review and enforcement of these instruments. Continued violence against women and girls and the critical need to ensure the incorporation of a gender perspective in all policies and programmes pertaining to health particularly reproductive health and HIV and AIDS is needed (MoHSS, 2008). If policies are not implemented it makes them rhetoric.

2.3.2 The National Standards on AFHS

The health of the adolescent is accepted globally, in Africa and in Namibia as a major concern (WHO, 2001). This led to the development of a strategy for adolescent health for the African region by World Health Organisation (WHO). This strategy provides a step-by-step guide to implementing AFHS: situation analysis; strategic plan development; standards for adolescents and youth friendly health services (AYFHS); health workers training, material development; monitoring and evaluation of tool development; and implementation of the standards at district level to scale up AYFHS. In Namibia, the AFHS approach was adopted in year 2000 and is currently being rolled out to more districts through the adoption of this regional strategy: situational analysis, developed standards and training health workers and are scalling up to more districts.

According to MoHSS Namibia, AFHS are those services, procedures, practices and other attributes that attract girls and boys between 10-19 years, providing them with a comfortable and appropriate setting, meet their needs and are able to retain them for follow-up and repeat visits (MoHSS, 2011). Lack of adolescent-friendly health services and inadequate policy orientation to meet adolescent health needs are some of the priority problems that the Region is trying to address (WHO, 2001, 2008). The national standards for AFHS is in line with the national policy on reproductive health and sets a minimum essential service package that is supposed to be available to adolescents to public health institutions in Namibia (MoHSS, 2011). The national standards for AFHS states that when an adolescent visits an AFHS for any service, they are to be given a comprehensive and complete package which includes information provision through counselling and education that covers a wide range of issue of concern to adolescents; a

wide range of clinical services that includes primary health care, contraceptive methods PMTCT and refferals only to mention a few. The government acknowledges that some of these services are not available in health facilities and where they are, adolescents themselves are not accessing them (MoHSS).

Besides the minimum package, the national standards also suggests six components and 20 characteristics to be considered by health facilities when implementing the AFHS initiative. The six components are adolescent participant; community support and participantion; adolescent friendly health service providers; adolescent friendly environment; adolescent friendly procedures and networking and collaboration. Each of these in turn has several characteristics. The national standards however gives health centres the freedom to innovate and design own 'appropriate' ways of implementing the AFHS which may be a loophole as this innovation or lack of may hamper effective adoption of the service. It is also left up to the health facilities to create adolescent friendly corners/ rooms within their old facilities; a process government may want to consider take a leading role.

2.4 AFHS Programme Challenges and Gaps

While the government has contributed to set the groundwork for the implementation of AFHS; policy and programmes, more work still needs to be done. Factors that determine and influence the adoption of the AFHS initiative by health workers and adolescents need to be identified, tabled and addressed. These include the issues of infrustrure, facility space, human resources, capacity building, awareness raising of adolescent health and of the AFHS initiative and attitudes and perceptions of all stakeholders of this initiative. The section will open with the attitudes of health workers and adolescent health seeking behaviour before discussion other challenges and gaps.

2.4.1 Health Worker Activities, Attitudes, Opinions & Beliefs

Many a time health workers' attitudes have been cited as one of the main reasons why adolescents do not access health services from health facilities. According to the MoHSS rapid assessment, this view has also been supported by the percentage of health care providers (40%) who felt that providing contraceptives to adolescents and youth encourages promiscuity (MoHSS, 2005). The national standards for AFHS also reiterates the fact that not all public health facilities offer AFHS and that where there are available; there is low utilisation of the service and this is necessitated by the unfriendliness of the environment which is related to the health care provider's attitudes and lack of privacy and confidentiality (MoHSS, 2011). In the MoHSS AFHS training manual, the same challenges are mentioned and they also add the lack of provision of individual attention to adolescents (MoHSS, 2002). The AFHS training

manual also alludes to the fact that health workers are reluctant to give condoms to adolescents (MoHSS). Despite the feelings from government to make matters worse, the joint assessment report revealed the AFHS has not yet been internalised nor seen as a core function of Primary Health Care (PHC) within the MoHSS itself (MoHSS 2005) something really worrying.

Health Care providers are said to judge young people who present with STIs including HIV and those who request for family planning (FP) service including condoms (Desert Soul, 2011). They discourage them to take family planning and condoms, bringing their personal values into the service (MoHSS, 2002). This view has also been supported by the MoHSS that states that STI treatment is often provided in a judgemental and moralistic manner which deters repeated utilisation of the service and creates negative publicity of the among adolescents and in the community (MoHSS). There is also the issue of the type of services being provided by health workers. They are not providing adolescents with health relate advice and IEC materials on sexuality, sexual health, contraceptives and consequences of early pregnancies, HIV and AIDS, STIs and unsafe abortion.

Despite these challenges perpetuated by health workers, the national standards for AFHS are clear on how adolescents are to be treated in public health facilities. When an adolescent visits a health facility for any reason, they are to be directed to specific rooms/corners/sections for adolescents and given a comprehensive and complete package that is integrated. This includes information provision through counselling and education that covers a wide range of issue of concern to adolescents; a wide range of clinical services that includes primary health care, contraceptive methods PMTCT and referrals only to mention a few (MoHSS, 2011). Some of these services are not being provided in AFHS and there is a lack of integration.

2.4.2 Adolescents' Health Seeking Behaviour

According to past research by UNICEF (2011) and the national review on AFHS by MoHSS, UNFPA & UNICEF (2005) and others, adolescents in Namibia just like those in other countries in the world are becoming sexually active in the early years of their life. This exposes them to a lot of health problems mentioned. They are also facing higher levels of morbidities and this is contributing to the reduction of life expectancy in Namibia. From these problems, it is apparent that they are not seeking health services adequately as the package mentioned earlier is comprehensive. While the actual reasons for the lack of uptake of AFHS are not known, literature by MoHSS, UNICEF, UNAIDS and other sources reveal that the barriers to access to these services include the unfriendliness of the AFHS caused by the health

workers' attitudes and their lack of privacy and confidentiality. While this is recognised as a very important HIV and GBV prevention intervention, little has been done to find out why this initiative is not thriving.

The Namibia Minister of Health, Dr. Richard Kamwi also alluded to the poor use of SRHR services by young people when he said:

> In Namibia, reproductive health services have been focusing more on safe motherhood and family planning, targeting adults and in a way neglecting the sexual and reproductive health needs of young people. This oversight could have contributed to poor utilization of health facilities by young people and increasing number of reproductive health problems among young people such as STI/HIV infections and unwanted pregnancies (MoHSS, 2008, p.3).

According to the Minister of Health, not all health facilities offer all services to young people. Family planning is apparently not easyly available to adolescents who need it. Other services like screening for sexually transmitted infections or treatment of post-abortion complications may also not be available especially in some deep rural settings; the issue of distance also contributes to unavailability. The absence of the provision of comprehensive sexuality education in schools contributes greatly to children growing up without knowing their sexual rights, thus compromising their reproductive health (Desert Soul, 2012). According to a study on experiences of pregnant adolescents in Uganda, adolescents often lack knowledge about consequences of unprotected sex such as unwanted pregnancy and sexually transmitted infections including HIV and AIDS. The study also states that in many cases, adolescents do not reveal their reproductive health problems and tend not to use the health care services they actually need. This may be due to inadequate information, limited access to financial resources or negative attitudes of health workers (Atuyambe, 2005). If one does not know a certain service exists, or the importance thereof, one cannot use it. Some young people fail to report cases of sexual abuse by family members, leading to lack of access to SRHR services (Desert Soul, 2011). In a small community, there is a high chance that most people would know each other and hence the information of the 'bad' sexual activities of some children is passed on to family members. This is a lack of privacy and may contribute the low level uptake of AFHS. A lack of integration of these services is also another issue which hampers the use of AFHS as it will become too time-consuming for adolescents whose majority is still in school (MoHSS, 2011).

2.4.3 Other Challenges

The MOHSS, UNFPA and UNICEF's joint rapid assessment on AFHS revealed a number of challenges particularly of infrastructure and space. Although the national standards specify the issues of privacy, confidentiality and personal attention, this is not easy to implement if there is not enough space. Facilities were built long before the intervention was introduced not all facilities will be able to effectively follow this condition (MoHSS, 2006).

There is also the problem of lack of health workers let alone ones trained to implement the AFHS (MoHSS, UNFPA, UNICEF, 2005). Despite this fact, all health workers who interract with adolescents are expected to implement AFHS and or handle adolescents in a friendly manner (MoHSS, 2011). This lack of staff is also exacerbated by high staff turnover especially of trained peer counsellors and the high mobility of health workers. Staff turnover is detrimental to the system because in most cases it leads to a lack of a transfer of knowledge; continuation and coupled with lack of retraining and refresher sessions may derail the process. It is commended that the government is currently continuing to train health workers; this however shows there is currently little going on vis a vis AFHS with the few trained ones. The joint assessment also revealed the challenge with the training health workers are receiving which is mainly focusing on primary health care (PHC) and maily implemented in clinics than in hospitals. This limits the choices of adolescents.

The AFHS package states the need to have adolescent consultative committees (ACC) and these, according to the joint assessment were established, trained but not fully functional yet in the majority of the districts but two (Engela and Mariental). Staff turnover may also be affecting the continuation of these meetings and this is derailing the process of consultations with communities and awareness raising with parents/ guardian/ teachers and and the adolescents themselves as this was one of ther committee's role.

2.5 Conclusion

Reporting the epidemiological successes it is undesputeable the global response to the HIV epidemic has been successful. It is obvious prevention and treatment interventions have worked. Many people are now literate about HIV, its transmission, impacts and prevention. There has been a decrease in the number of new infections and the number of HIV related deaths. The HTC uptake has also increased leading to an increase in the number of PLHIV on ART and pregnant mothers enrolling on PMTCT in sub- Saharan Africa particularly in Namibia. However, because of the nature of HIV and the epidemic in general, the problem is still there. While ART has helped in lessening the burden of HIV, about half of the people

eligible for treatment are not receiving it. There are still millions of people living and affected with HIV and about half of these are below the age of 15. This is why adoption and implemetation of interventions for adolescents like AFHS should be hastenned. This literature review has shown efforts by the Namibian government to set the legal framework for the implementation adolescent programmes like the AFHS initiative, however; it also revealed some gaps in terms of on the ground implementation of the programme. A number of interventions are still required particularly for adolescents who are at a difficult stage where they fail to uptake SRHR services despite their availability and accessibility. There are a combination of factors that determine the adoption of AFHS and these include effective policy implementation, availability of human resources, who are trained and well equipped, availability of adequate and appropriate infrustructure, a supportive environment for adolescents both at home and health centres and positive attitudes and mindsets from both adolescents and health workers. These problems need government's attention. The next chapter will discuss the methodology that was used to gather data for the study.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 Introduction

This study was conducted at Katutura health centre (KHC) a public health clinic in Windhoek, Namibia. Katutura is one of the biggest townships in Namibia and situated in the Windhoek district. The facility provides both primary health care and an antiretroviral therapy (ART) programme. It has a staff compliment of about 72 in both the general and the ART clinics. This facility was selected for the study for two reasons, it is one of the few centres that was part of the Government AFHS programme pilot project, with some nurses trained and has started implementing the programme. It is also in Windhoek where the researcher is based and it was felt it would simplify the collection of data.

In this section, both the methodology and methods that were utilised in the study are outlined. The methodology outlines the assumptions that guided the choice of the method. Further the method describes exactly what was done and what techniques were used collecting and analysing the data.

3.2 Problem Statement

Health statistics on adolescents show high incidences of teenage unwanted pregnancies, unsafe abortions, baby dumping, maternal ill health, mental health, early marriages, alcohol, drug and substance abuse and HIV (MoHSS, 2011). A high incidence of these problems may be an indicator of lack of or underutilisation of AFHS by adolescents because education, counselling and treatment of adolescents are part of the AFHS package. These problems faced by adolescents can be reduced greatly by an effective implementation of AFHS. While this age group has one of the lowest HIV prevalence its rate of increase in STIs including HIV needs to be curbed. There is also, a recognisable under implementation of AFHS by health workers and in return underutilisation of the service by adolescents in Namibia.

While the government is making an effort to provide AFHS actual implementation on the ground is a different issue. There are a number of reasons that may be causing this lack of adoption of AFHS. The health workers may be lacking the capacity to provide the service effectively, leading to them not implementing the package or the adolescents not utilising the service. The health facilities may lack the needed infrastructure to implement the AFHS programme for example private rooms to be used by adolescents and the service end up being unfriendly to adolescents. This may lead to lack of motivation by health workers and be deficient utilisation by adolescents. It may just be the attitude of health workers

towards the adolescents coming for HIV and SRHR services that leads to the underutilisation. The government has, however, made of strides and efforts in the area of AFHS. They have developed the AFHS national standards that clearly stipulate the minimum package, the process of implementation and the roles and responsibilities. It has trained and oriented a number of health workers on the implementation of the service.

The reseach question was: What factors are associated with the adoption of adolescent friendly sexual and reproductive health service practices by health workers at Katutura Health Centre, Namibia?

3.3 Objectives of the Study

The objectives of the study are:

1. To determine the knowledge and understanding of the AFHS programme by health workers at KHC, Namibia.
2. To establish the factors that are associated with the slow adoption of adolescent friendly health practises by health workers at KHC, Namibia.
3. To evaluate the approach that the MoHSS is using to introduce and implement the AFHS programme to the health workers.
4. To recommend better approaches to introducing new programmes to health workers and to provide guidelines for interventions that increase the uptake of AFHS at public health institutions in Namibia.

3.4 Research Methodology

The methodology chosen for a research project serves as the roadmap for the direction of investigations.

3.4.1 Research Approach/ Philosophy

A quantitative non-experimental descriprive research approach was used in this study. A quantitative study is a type of study that collects some numerical data to answer a given research question and a descriptive research focuses on describing some phenomenon, event or situation (Christensen, Johnson & Turner, 2011). A qualitative research study is one that collects some type of nonnumerical data for example, statements by particiants during interviews or recorded in books; to answer a given research question. These research approaches have their advantages and disadvantages; a quantitative non-experimental descriprive research approach was chosen as it is the best approach to use when investigating a new area (Christensen). The goal of this study was to get a picture of the AFHS

programme and situation at KHC. This approach was also chosen because of its descriptive nature and the other project objective was to focus on describing AFHS phenomenon and situation.

3.4.2 Research Design

This was a cross-sectional study where data was collected during a single and brief period of time. The data was collected using a survey of the whole population of health workers. A survey research method is where participants fill out a questionnaire or are interviewed about their attitudes, activities, opinions and beliefs (Christensen et al, 2011). In answering the research question, the researcher wanted to establish the attitudes, beliefs and opinions of health workers on the AFHS approach and on adolescents themselves. Surveys are initially conducted to answer the question 'how many', 'how much', 'who' and 'why' (Christensen). A cross-sectional survey design was chosen for this study because of its strengths in measuring attitudes, activities, opinions and beliefs. The study was conducted over a short period of time and information was sought from the sample once. However, a different cross section of respondents was used that is, from all nurses, counsellors, doctors, pharmacists, radiographers and clerks. Three processes were used in the study namely, collection of data, coding of data and analysis of data (Glaser & Strauss, 1967).

3.5 Sampling Procedures

It is difficult if not impossible to conduct research using a universe (all the subjects). Whether qualitative or quatitative methods will be employed it is only practical to select a representative sample from the universe to be included in a survey.

3.5.1 Sampling Methods and Population

The need to avoid sampling errors led to conduct a census of the entire population of health workers instead of sampling. A census is the collection of data from everyone in the population (Christensen et al, 2011). This also helps in getting a more accurate indication of the situation under study as information is sought to all people involved. The inclusion criteria was therefore simple; a crosssection of all KHC health workers that regularly interact with patients, that is, medical doctors, nurses, phamarcists, community counsellors, front desk clerks (who receive payments) and a radiographer. The exclusion criteria was also pretty straight forward; other KHC employees that do not interact with patients that is, data clerks and other health workers that are housed at the clinic but are not KHC stuff, for example, the community outreach department which has a separate programme and mandate.

A list of all the elligiable health workers were acquired from the facility administration office and the total number came to 65. A total of 56 health workers accepted to participate in the study and the questionnaire, 46 of which returned it within a stipulated three weeks data collection period. The data collection period was carefully determined to ensure enough time for health workers to complete the questionnaires and at the same time trying to avoid polution of the results. The remaining 9 questionnaires were either not returned on time or not returned at all. This attrition rate was due mainly to the nature of the health worker's busy work schedules which are also not fixed, particularly nurses. These may work two to three times a week and be off the rest of the ensuing week. The other four employees were on leave and one was seconded to another facility. The five employees that were eligiable but did not participate, two thought they were too old to participate, two indicated they were too busy and one said they did not want to and also siting they were too busy.

As demonstrated in figure 3.1 and table 3.1 the population had a cross-section, not only of job positions, which brought about a variety of different experiences, but of age groups. In implementation of AFHS and according to the national standards, the age of health workers is a very important factor.

Figure 3.1

Respondents' Job Positions

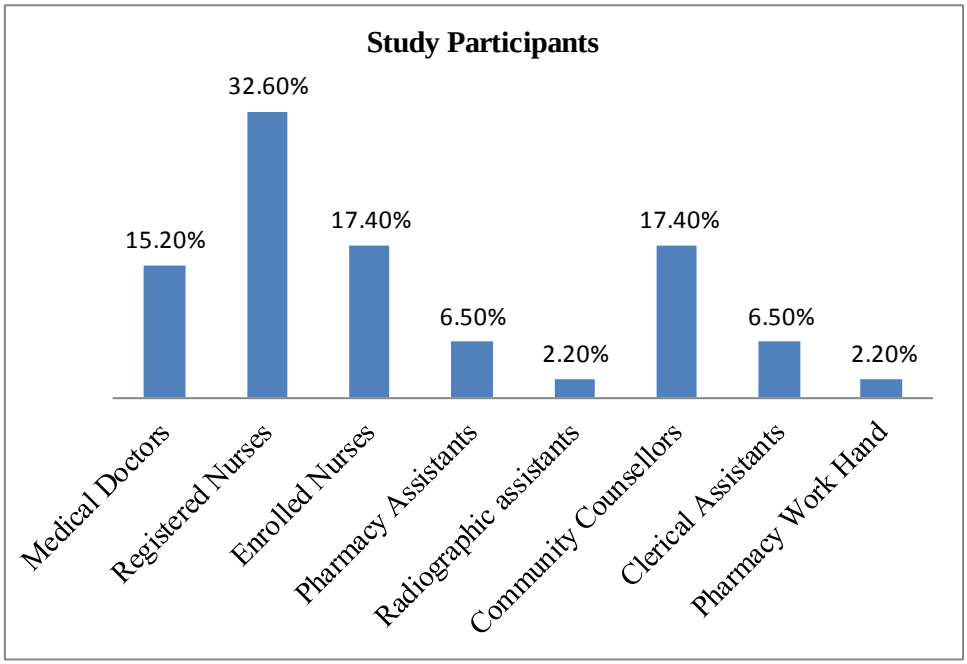


Table 3.1

Respondent's Age Ranges

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 25	2	4.3	6.7	6.7
	25 to less than 30	7	15.2	23.3	30.0
	30 to less than 40	12	26.1	40.0	70.0
	40 to less than 50	2	4.3	6.7	76.7
	50 and above	6	13.0	20.0	96.7
	missing	1	2.2	3.3	100.0
	Total	30	65.2	100.0	
Missing	System	16	34.8		
Total		46	100.0		

3.5.2 Instruments

A questionnaire was used as the data-gathering instrument for this study. This is a self-report data collection instrument that is filled out by the research participant (Christensen, Johnson & Turner, 2011). A questionnaire was developed to be administered to the target groups, the KHC health workers.

Three methods were used with questionnaires: The main method was self-administered questionnaires, where participants received the questionnaires and filled them on their on. There were a few incidences where 4 participants made a request to either do a face to face interview with them on the questionnaire or some sections thereof. Although not utilised in the end, some few respondents indicated telephone interviews would be best for them. The questionnaire was semi-structured with both open and closed questions.

3.5.3 Data Collection Procedures

Evidence using both primary data collected was employed in the field through self-administered questionnaires and secondary data collected in the literature review. A literature review of existing data gathered from past research include documents and publications that discuss and interrogate the factors associated with the adoption of AFHS by health workers and HIV, SRHR and young people, particularly their health seeking behaviours vis a vis the use of AFHS. Critical national policies, standards and protocols on AFHS, SRHR, gender, women's rights and HIV were also reviewed. This review was instrumental in the conceptualisation of the research as well as in drawing together the background information critical to underpin the survey.

3.6 Conclusion

This study was conducted at katutura a primary health care clinic centre and a quantitative, non-experimental descriptive research approach was used. A cross-sectional survey design was also selected for this study and the use of a census was prefered over sampling. Mainly paper-and-pencil instruments were used; questionnaires were mainly self-administered with option for telephone interviews and one-on-one methods kept as options because of the nature of and requests from participants. The next chapter presents, interprets and discusses the results of the study.

CHAPTER FOUR
REPORTING AND DISCUSSION OF RESULTS

4.1 Introduction

In this chapter the results of the study are presented. The first section computes all the quantintative findings in the form of tables and graphs. Qualitative findings are also presented in this section. The following section presents the bi-variate analysis findings of six dependent variables on the factors associated with the adoption of AFHS and the contingency tables thereof, to show the relationships of the dependent and independent variables. The reseach question was: What factors are associated with the adoption of adolescent friendly sexual and reproductive health service practices by health workers at Katutura Health Centre, Namibia?

The aim of this study was to establish the reasons why there is a slow adoption and implementation of the adolescent friendly health service practices by health workers in order to improve the adoption thereof and to contribute to the health seeking behaviour of adolescents. The objectives are:

1. To determine the knowledge and understanding of the AFHS programme by health workers at KHC, Namibia
2. To establish the factors that are associated with the slow adoption of adolescent friendly health practises by health workers at KHC, Namibia.
3. To evaluate the approach that the MOHSS is using to introduce and implement the AFHS programme to the health workers.
4. To recommend better approaches to introducing new programmes to health workers and to provide guidelines for interventions that increase the uptake of AFHS at public health institutions in Namibia.

4.2 Findings

This section presents the sample's characteristics; demographic, social and economic; the sample's knowledge and understanding of the AFHS programme and the controversy on adolescents and contraceptive use.

4.2.1 Demographic and Socio-economic Charecteristics

Table 4.1

Participant Characteristics

Charecteristic	Frequency	Per cent
Sex		
Female (F)	24	66.7
Male (M)	12	33.3
Age		
Less than 25	2	6.7
25 to less than 30	7	23.3
30 to less than 40	12	40.0
40 to less than 50	2	6.7
50 and above	6	20.0
Job Position		
Registered Nurse	15	32.6
Enrolled Nurse	8	17.4
Medical Doctor	7	15.2
Community Counsellor	8	17.4
Pharmacy Assistant	3	6.5
Radiographic Assistant	1	2.2
Clerical Assistant	3	6.5
Pharmacy Work Hand	1	2.2
Experience		
Less than five years	16	34.8
Five to less than 10 years	16	34.8
Ten to less than 15 years	4	8.7
Fifteen years and above	10	21.7
Language		
Oshiwambo	20	43.5
Otjiherero	3	6.5
Khoekhoegowab	3	6.5
Lozi	1	2.2

Rukwangali	1	2.2
Afrikaans	3	6.5
Other	15	32.6
Education		
Secondary	8	17.4
Tertiary	36	78.3

Eighty two percent of the sample participated in the study of which 67% respondents were female and 33% were male. The majority of the respondents (78.3%) had tertiary education while 17% had secondary education. The other languages were Swahili, Otjidhemba, Kikuyu, Thimbukushu, French, Shona, Spanish, Tswana, Portugues, Bemba, Bengali and Nyemba (table 4.1).

4.2.2 The AFHS Programme

Table 4.2

AFHS Knowledge and Understanding

Characteristic	Frequency	Percent
Knowledge of the Programme		
Yes	18	40.9
No	26	59.1
If trained on the Programme		
Yes	7	35.0
No	13	65.0
Knowledge of colleagues trained		
Yes	9	65.3
No	5	35.7
If the Programme was introduced properly		
Yes	9	45.0
No	11	55.0
If the Programme is being effectively implemented		
Not at all effective	4	23.5
Not very effective	7	41.2
Somewhat effective	6	35.3
Very effective	0	0

As shown in table 4.2, 65% of the participants did not receive AFHS programme training and over 59% of them do not even know about it. This could mean the pace at which the programme is being rolled out is slow as it was introduced in Namibia in year 2000 (MoHSS, UNFPA & UNICEF, 2005; MoHSS, 2011).

The few participants who knew about the AFHS programme, however, managed to define it in one way or the other with some stating the goals, tenants and characteristics of the programme, how the programme should be run and the way adolescents should be handled. This could mean some health workers are motivated to understand and adopt the programme as the number of those who knew about the programme is including those who were not trained. A good number of respondents however wrongly used the words adolescents, youth and young people interchangeably. This may mean a lack of understanding of the differences in these.

Those who knew about the programme expressed their feelings about it in about three major angles. There were those who were trained or got comprehensive feedback from trained collegues; those who were not trained and did not get proper feedback or reporting on the training and way forward; and then those that felt the AFHS package is good despite the issue of training and or feedback. Most of the comments were similar and some few of them said “I am not well acquainted with the package as feedback was not yet given”; “It is being neglected a bit here, no corner, no IEC materials/ poster even on adolescents and the programme to show that it is available, no initiatives for young people”. Those who felt the programme is good gave comments such as “I feel it’s a good programme but everyone including parents should be trained and maybe get a copy of the package as it is not easy to implement when parents say different from what the health workers are educating…”; “good programme where consultants and information provision are done simulteneously”; “ good package where adolescents can seek all services which help reduce marternal mortality, teenage pregnancies and HIV”. It was further stated “the programme is good but too much, needs a lot of time, staff and commitment”. These feelings from participants demonstrate that the programme is appreciated by the people who are to adopt it and that adolescents could actually benefit from it.

Participants’ responses on the feelings about the way the programme was introduced were diverse but similar. They ranged from the issues of how the training was done “only one personnel is trained”; “I was given a short explanation/ feedback from the training; it was given once without a written report”, then there were issues of length of the training, reporting of the training, monitoring visits, supervision through

to issues of physical resources "I was trained for two weeks, however the barriers are with facility level set up, there is no proper infrustructure" one EN said. It was clear the training was conducted with a few nurses and those who were trained felt the training was sufficient for implementation. The rest of the health workers felt everyone needed the training. Some health workers were fortunate to get some form of unofficial feedback from the training but others did not.

Table 4.3

Participant Responses to AFHS Quiz

Response / Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The programme rollout has not yet started	14.3%	28.6%	23.8%	23.8%	9.5%
2. The programme has started but there is no facility space for effective implementation	14.3%	14.3%	4.8%	33.3%	33.3%
3. The programme is running but adolescents are not coming because of the health worker reputation	38.1%	38.1%	14.3%	4.8%	4.8%
4. The health workers do not agree with the issue of tolerating with adolescent sexual activities	33.3%	52.4%	0	14.3%	0
5. The attitudes of health workers towards adolescents are preventing effective implementation of the programme	47.6%	23.8%	9.5%	19.0%	0
6. The health workers are not friendly to adolescents who require HIV and SRHR information	60%	25%	10%	5%	0
7. Not all health workers were trained on AFHS and therefore adolescents face challenges in some instances	5%	0	5%	55%	35%
8. The package is asking for too much and health workers don't really have the time to follow it wholly	15%	15%	15%	40%	15%
9. Health workers judge adolescents who	38.1%	38.1%	9.5%	9.5%	4.8%

present with STIs and this is one of the reasons why participation is low					
10. When adolescents visit health facilities they want to be given health related advice and IEC materials but this is not happening.	19%	19%	23.8%	28.6%	9.5%

Participants who responded to the quiz in table 4.3 disagreed with the statement 'the programme is running but adolescents are not coming because of the health worker reputation' the same way they disagreed they do not agree with the issue of tolerating adolescent sexual activities. They also strongly disagreed with the statement that they are not friendly to adolescents who require HIV and SRHR information and one which indicated their attitudes towards adolescents are preventing effective implementation of the programme. This finding is not in line with the National Standards for AFHS where the government admits there is low utilisation of the AFHS and this is necessitated by the unfriendliness of the environment which is related to the health care provider's attitudes and lack of privacy and confidentiality (MoHSS, 2011). These differences could mean the respondents were being defennive, which is not good for adoption and effective implementation or they were concious of the fact that this study was just for their facility. These participants, however, strongly agreed there is no facility space for effective implementation and not all health workers were trained on AFHS and therefore adolescents face challenges in some instances. They had mixed feelings on whether the AFHS programme roll out had started. This could be a sign that either the programme has actually not 'properly' started or health workers do not understand it to the extent of failing to recognise its roll out.

The qualitative data provided responses; from what was required for the AFHS programme to be effectively implemented - all health workers must be trained, oriented on the programme on routine basis although only a few can be selected to be dealing with adolescents. They also cited the need to make the environment adolescent friendly by having a large well ventileted lockable private room/corner/separate clinic, adolescent friendly health workers, stocked with relavant Information Education and Communication (IEC) materials and the need for the discussions to be focused on important issues that affect adolescents for example, issues of sex (when to start, how, with whom), contraceptives, FP, STIs, HIV and AIDS, unwanted pregnancies, teenage pregnancies and complications of all the above mentoned. The issue of time management and workload also came out strongly and the programme would need intensive supervision and feedback. Some felt policies on adolescents must be made available at facilities; to create awareness (health workers to identify adolescents in screening rooms); to have events for both

staff and adolescents and team work betweeen health workers and adolescents. One RN simply said “I don’t know!”. These responses are obviously from people who were trained in AFHS and understand it very well.

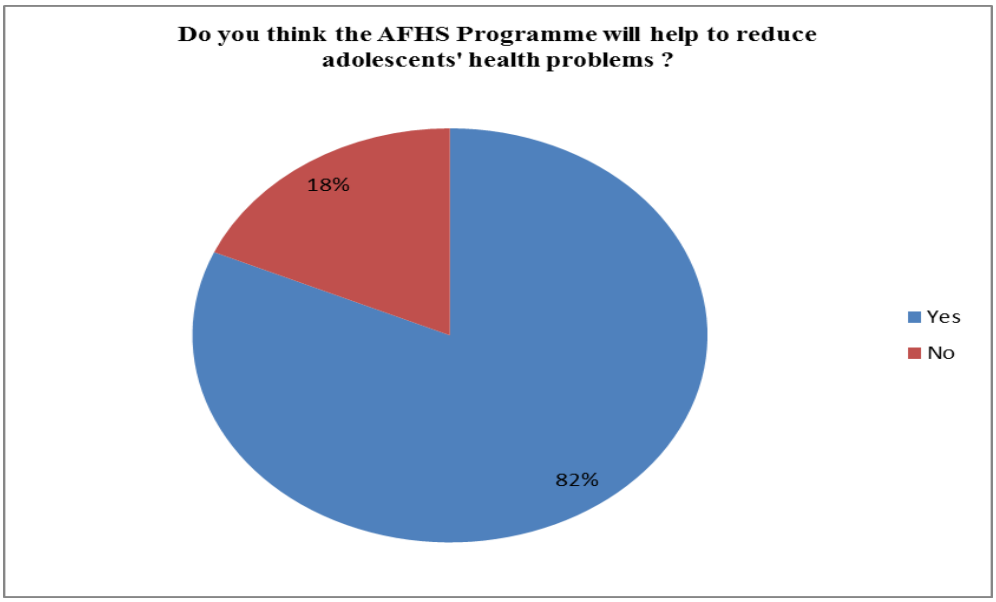
Figure 4.1

Training in AFHS

Most of the participants who responded to the question on what they felt was their role in the effective implementation of the programme started their responses with the phrase ‘with training’ and these ranged from commiting themselves to be more competent and sensitive to adolescents and to try and understand their needs; to create community awareness about the programme; to advocate for youth programmes, to orient fellow team members who were not trained to the need to understand the programme and the importance of confidentiality and providing adolescents with all the information they need. One concluded by saying “If the environment is friendly (with moral support), the adolescents will attend”. Two respondent did not mince their words, one simply said ‘none’ and the other, ‘nothing at the moment as I was not trained’ (figure 4.1). Respondents could actually fit themselves in the AFHS programme through identifying some roles and responsibilities they could do. This could mean they are motivated and ready to start implementing the programme.

4.2.3 Adolescent Health

Figure 4.2
Usefulness of AFHS



An overwhelming majority (82%) of the participants believed the AFHS initiative could help reduce adolescents' health problems. This response could have been necessitated by the training or orientation some of the respondents received or their knowledge of adolescent needs.

Participants gave some suggestions to the government on better ways of introducing new programmes and these were: training of all health workers; programmes to be introduced one at a time to avoid accumulation; time management, employment of more staff members and having a multi-disciplinary team approach in introduction of new programmes that allows the involvement of different ministirial levels. Suggestions specific to the AFHS programme were mostly on training and space; facility infrastructure to allow for new programme implementation. They suggested the AFHS programme should immediately be introduced in schools and health institutions; the introduction of the programme to parents/guardians; the provision of IEC materials; regular health education, use of community conversations and media (newspapers, theatre and different cultural participation) in the awareness raising of the programme. Respondents could have given these suggestions because of their past experiences with new programmes from how they should be introduced for them to be successful, the ground work that is needed for example training of human resources and their understanding of how the AFHS could become effective.

Table 4.4

Knowledge of adolescent health

Characteristic	Frequency	Percent (%)
Adolescents facing a lot of HIV & SRHR problems		
Yes	30	75
No	10	25
Do adolescents need specialised programmes		
Yes	39	95.1
No	2	4.9

Health workers acknowledge the fact that adolescents face a lot of SRHR problems and need specialised programmes like the AFHS initiative (table 4.4).

Participants who responded positively to the question on whether adolescents face many HIV and SRHR problems correctly gave the following as examples of the problems: STIs including HIV which has a consequance later on SRHR; rape; early/teenage/unwanted pregnancies, unsafe abortions, baby dumping; school drop outs, unemloyment, prostitution that may lead to passion killings; psychological problems, birth control issues, birth complications; lack of education on how to use condom; lack of FP; judgemental relationships with health workers; lack of experience and confidence to negotiage safe sexual practices; easily succumb to peer pressure; lack of access to interactive personnel for contraceptives and reproductive health education and poor information about STIs. These were then also asked if they thought the AFHS programme would help to reduce the problems listed above and these were their thoughts: adolescents will get more information on how to prevent risky behaviours, STIs, unwanted pregnancies and HIV and AIDS. 'Knowledge is power, if you are aware of all the consequencies and well informed, you will avoid getting mixed up with irresponsible behaviours' one young nurse said. They will also be educated on how to deal with health and sexual matters like delayed sexual debut and condom use negotiating skills. Some felt adolescents would benefit from having health workers dedicated to them and free HIV facility visits and others felt the programme will instill some responsibility within adolescents. These responses show health workers have some knowledge on AFHS and adolescent needs.

Table 4.5

Perceived importance of programmes for adolescents

Programme	Frequency	Percent
Counselling and education		
Yes	34	81.0
No	8	19.0
Contraceptive methods including condoms		
Yes	29	69.0
No	13	31.0
Health education on abstinence, gender equality and nutrition		
Yes	26	61.9
No	16	38.1
STI screening including HIV management		
Yes	25	59.5
No	17	40.5
Health Information Education and Communication (IEC) materials		
Yes	22	52.4
No	20	47.6

Table 4.5 indicate the programmes thought to be vital to adolescents in order of participants' perceived importance. Respondents could have highly ranked counselling and education and contraceptive methods because they believe adolecents need information and education on health and FP. Despite the the lack of IEC materials on adolescent health was really emphasiced in qualitative responses, the IEC programme was lowly ranked.

4.2.4 ADOLESCENT FRIENDLY ENVIRONMENT

Table 4.6

Opinions on Clinic's Adolescent Friendliness

Characteristic	Frequency	Percent
Is the adolescent consulting room convinient and accessible		
Yes	2	5.1
No	5	12.8
There is no consulting room for adolescents	32	82.1
Is there privacy in the adolescent consultation room		
Yes	9	25.7
No	26	74.3
Are IEC materials availble in the consultation room		
Never available	19	57.6
Not often	3	9.1
Sometimes	10	30.3
More often	1	3.0

Respondents were requested to suggest what should be done to improve space, privacy and confidentiality: their responses on the issue of room were diverse; from a spacious room that does not communicate with other rooms; enough ventilated room/space that fits all, room to be allocated for that at the clinic, adolescent quiet corner not centre of clinic, adolescent space to be near the the facility to cater for those who could be embarrased to enter deep iniside; to use a place outside a health facility with dedicated times for consultations. On the issue of privacy; some felt it is a matter of a lockable room and not facing other consulting rooms, others felt adolescents needed to be assured of privacy in the consulting room; the issue of one health worker dealing with them again, training on privacy and confidentiality and the issue of individual and not group consultations. Respondents on confidentiality agreed there is need to reassure adolescents of such and to actually keep discussions confidential. Some said there is need to establish trust and competence when dealing with sexual problems; the issue of only one health worker dealing with adolescents was once again raised with emphasis on anonymity. Some direct comments were "with enough space then confidentiality is gauranteed!"; "If there are no disturbancies, then there will be confidentiality" and lastly "Nurses know how to be confidential, but a lockable room is one that is needed". After being asked if they give any special treatment to adolescents,

most of the respondents said no, and a few said sometimes. Respondents understand the importance of space, privacy and confidentiality in dealing with adolescents.

4.2.5 Family Planning

Table 4.7

Feelings and opinions on contraceptive use and FP

Characteristic	Frequency	Percent
Feelings towards giving contracetives to adolescents		
Yes	36	90.0
No	4	10.0
Personally giving adolescents contraceptives		
Never	11	24.0
Sometimes	18	40.0
Always	16	35.6
Personally offering condoms to adolescents		
Yes	39	86.7
No	6	13.3
Facility having all types of contraceptives available		
Yes	17	38.6
No	18	40.9
I dont know	9	20.5
Facility offering all types of contraceptives available to adolescents		
Yes	26	57.8
No	7	15.6
I don't know	12	26.7
Feelings on the use of FP by adoloscents		
Strongly disapprove	6	13.6
Disapprove	4	9.1
Neutral	10	22.7
Approve	12	27.3
Strongly approve	12	27.3
FP services being available for all at the facility		

Yes	40	90.9
No	0	0
I don't know	4	9.1

It is interesting to note while an overwhelming 90% of the respondents felt adolescents should be given contraceptives, only 36% always give them out. Also although FP services are available for all (91% of respondents confirmed it) there were mixed feelings on the use of FP by adolescents.

Participants' comments and feelings towards the provision of contraceptives to protect unwanted pregnancies and STIs including HIV to adolescents were similar with slight differences on what should be emphacised (table 4.7). Most of the ones who shared their comments felt contraceptives have the potential to make a meaningful contribution to the reduction of unwanted pregnancies; STIs including HIV, abortions, maternal mortality and would help adolescent girls finish school: "One is never too young to get contraceptives because teenage girls in Africa start experiencing sex at the age of six playing 'house' games". Some felt adolescents should rather get more information on STIs and HIV and AIDS and not more on unwanted pregnancies; while others were of the opinion that they should first be given health education on sexuality as they felt the damage caused by contraceptives is better than that of unwanted pregnancies. There were those that were in favour condom education for prevention of STIs including HIV and unwanted/teenage pregnancies and; "other contraceptives should always be used together with condoms to prevent HIV". Those for these views agreed on the need to educate adolescents on the advantages and disadvantages of all types of contraceptives, condoms, injectable and orals.

There were some who were clear they do not think adolescents should get contraceptives at all 'I do not think adolescents should be given contraceptives because they will think it is normal for them to indulge in sexual activities instead of abstinence' one RN said.

Table 4.8

Percieved best FP methods for adolescents

FP method	Frequency	Percent
Condoms		
Yes	40	88.9
No	5	11.1
Contraceptive Injection		
Yes	29	64.4
No	16	35.6
Oral Contraceptive		
Yes	20	44.4
No	25	55.6
Contraceptive Patch		
Yes	8	17.8
No	37	82.2
Contraceptive Implant		
Yes	4	8.9
No	41	91.1
IUD		
Yes	4	8.9
No	41	91.1
Withdrawal		
Yes	4	8.9
No	40	88.9
Rhythm method		
Yes	2	4.4
No	41	91.1
Surgical sterilisation		
Yes	0	0
No	46	100

In table 4.8 are contraceptives thought to be best for adolescents in order of participants' perceived preference. None of them felt surgical sterilisation is an option for adolescents. The possible reasons why

condoms are on top of the rank is their ability to prevent STIs, HIV and pregnancy and perhaps the promotion of dual protection. Dual protection is one effective way of protecting adolescent girls from getting STIs including and this is also supported by the findings from a research study carried out in Kabarole district, western Uganda (Chacko, Kipp, Layng & Kabagambe, 2007).

Participants were asked if FP services are available for all at KHC and the responses were almost unanimous. The response was positive with others adding more information like the availability of a FP nurse, the times they operate and the types of FP mostly offered to adolescents. One participant said "all FP methods are available except for sterilisation, IUD and loop which we cannot recommend for adolescents" and another with concern, "teenage girls as young as 13 years receive contraceptives including injections".

Table 4.9

Participant Responses to a Quiz on contraceptives

Response / Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Contraceptives are not good for the health of adolescent girls and therefore should not be given.	35.6%	33.3%	11.1%	15.6%	4.4%
2. Providing contraceptives to adolescents encourages promiscuity.	16.3%	34.9%	11.6%	27.9%	9.3%
3. Adolescents do not need parental/guardian/spousal approval to use or not use contraceptives but can make their own decisions.	17.4%	19.6%	17.4%	30.4%	15.2%
4. When possible health workers should notify parents/guardians if an adolescent collects a condom, requests for contraceptives, is pregnant, has an STI or any of their sexual activities.	36.4%	18.2%	11.4%	27.3%	6.8%
5. Adolescents should be given all the information about the dangers of contraceptive use.	0	2.2%	2.2%	31.1%	64.4%
6. Adolescents should be given all the	2.2%	0	0	24.4%	74.3%

information about the dangers of early sexual debut.					
7. Condoms prevent STIs including HIV and unwanted teenage pregnancies so they should be available to them.	6.7%	2.2%	0	33.3%	57.8%
8. Health workers are not comfortable giving adolescent girls certain types of contraceptives	15.6%	26.7%	15.6%	37.8%	4.4%
9. Adolescent parents are not getting the services meant for adolescents	16.3%	20.9%	23.3%	27.9%	11.6%
10. IEC for contraceptive methods are not always available	12.8%	17.9%	17.9%	30.8%	20.5%

Participants (table 4.9) who responded to the quiz above strongly disagreed that 'contraceptives are not good for the health of adolescent girls and should not be given'. At first sight this finding looks like it differs from what was reported by the MoHSS rapid assessment study on AFHS where 40% of health workers felt providing contraceptives to adolescents and youth encourages promiscuity (MoHSS, 2005) but it does not. This is so because the same respondents have mixed feelings on statement 2 'providing contraceptives to adolescents encourages promiscuity' (28% actually agree) and they also have strong feelings about emphasising the dangers of contraceptive use to adolescents (statement 5). This could mean health workers have strong feelings about giving contraceptives to adolescents considering this study is taking place 10 years after the AFHS initiative was introduced. There were mixed feelings on statements 3 and 4: 'whether adolescents require parental/guardian or spousal approval to use contraceptives' and 'whether health workers should whenever possible notify parents/guardians of their adolescents' sexual activities'. This revelation could mean health workers feel adolescents are too young to have serious sexual activities that involve the use of contraceptives and can certainly not make decisions on the latter own their own.

4.3 Bivariate Analysis and Factors Significantly Associated with the adoption of AFHS

This section presents the results from bivariate analysis of the six dependent variables (appreciation of adolescents' health problems, feelings towards the AFHS' potential to reduce these problems, adolescents' need for specialised programmes, adolescent's use of contraceptives, health worker's supply of contraceptives and health worker's supply of condoms) against the other factors explored during the survey. Data was analysed using IBM - SPSS version 20 and the Chi-square values, Degrees of Freedom (df) and pvalues are presented here. A probability value of $p<0.05$ was adopted.

4.3.1 Bivariate analysis

Table 4.10

Bivariate analysis results

Dependent Variables → **Factors** ↓	**17. Do you think adolescents face a lot of HIV & SRHR problems?**	**19. Do you think the AFHS programme will help to reduce these health problems?**	**21. Do you think adolescents need specialised programmes like the AFHS programme for their health to improve?**	**28. Do you think adolescents should be given contraceptives to protect unwanted pregnancies and STIs including HIV?**	**30. Do you personnally give adolescents contraceptives?**	**31. Do you personally offer condoms to adolescents?**
Demographic factors						
Sex	0.151	0.448	0.179	0.673	0.001*	0.771
Age	0.227	0.625	0.825	0.385	0.530	0.528
Position	0.076	0.000**	0.713	0.771	0.004*	0.236
Experience	0.011*	0.392	0.256	0.241	0.029*	0.576
Education	0.040*	0.000**	0.106	0.360	0.209	0.895
The AFHS programme						
Do you know about the AFHS programme	0.431	0.043*	0.851	0.401	0.193	0.292
Were you trained in AFHS	0.688	0.197	0.179	0.485	0.990	0.452

Any health worker you know was trained?	0.317	0.460	No statistic was computed because the response was a constant yes.	0.188	0.772	0.164
Do you think the programme was introduced properly?	0.375	0.303	0.279	0.381	0.893	0.353
Is the programme being effectively implemented	0.411	0.378	0.504	0.309	0.004*	0.378
Adolescent friendly environment						
Is the location of the adolescent consulting room convinient & accessible?	0.301	0.881	0.809	0.434	0.527	0.692
Does the consulting room ensure privacy?	0.874	0.269	0.372	0.314	0.662	0.201
Are IEC materials available in this consulting	0.111	0.154	0.599	0.437	0.490	0.646

room						

*Indicates p<0.05; **Indicates p<0.01

The bivariate analysis table (table 11) presents a pvalues of the six dependent variables and a number of carefully selected independent variables. About 9 areas of significance were identified (stared) and just to give some examples from the first section for sample characteristics: knowledge of adolescents' health problems is significantly associated with work experience (p=0.11) and level of education (P=0.40); faith in the programme's potential to help reduce adolescent problems was also significanly assocated with job position (p=0.00) and level of education (p=0.000) in the same way supplying contraceptives to adolescents, sex (p=0.001), job position (p=0.004) and work experience (p=0.029). These and others are discussed in the next section.

4.3.2 Contingency Tables: Factors significantly associated with the appreciation of adolescents' health problems

This section discusses factors significantly associated with the appreciation of adolescent's health problems particularly work experience and level of education.

Table 4.11

Contingency table of appreciation of adolescents's health problems by work experience

		How many years of experience do you have working in a public health facility?			
		less than 5 years	5 to < 10 years	10 to < 15 years	15 years and above
Do you think adolescents face a lot of HIV and sexual and reproductive health problems?	Yes	86.7% (13)	83.3% (10)	100% (4)	33.3% (3)
	No	13.3% (2)	16.7% (2)	0	66.7% (6)
Total		100% (15)	100% (12)	100% (4)	100% (9)

Pearson Chi-Square value -11.200[a], df-3, p=0.011

Table 4.11 demonstrates appreciation of adolescent health challenges declines with increasing experience. Alternatively appreaciation of the same challenges is more amongst the less experienced health workers. This could be because the more mature health workers did not get training or enough opportunities for

orientation in AFHS. The National standards infact reports they have introduced in-service training of healthworkers providers where AFHS modules are now incorporated in the curriculum for pre-service training of nurses at the University of Namibia. The less experienced health workers are most likely to also be younger and able to relate better to the problems of adolescents and youth or trained.

Table 4.12

Contingency Table of the appreciation of adolescents's health problems by level of education

		What is the highest level of education that you have completed?	
		Secondary	Tertiary
Do you think adolescents face a lot of HIV and sexual and reproductive health problems?	Yes	40% (2)	81.9%27
	No	60% (3)	18.1% (6)
Total		100% (5)	100% (33)

Pearson Chi-Square value -4.201[a], df-1, p=0.040

Appreaciation of adolescent's HIV and SRHR problems is positively correlated with increasing education. This could be because the highly skilled staff like Doctors and Nurses could have received training on adolescent health in one way or the other and encounter more of adolescent health challenges than less skilled staff with secondary education (table 4.12).

4.3.3 Factors significantly associated with feelings towards the AFHS Programme's potential to reduce adolescents' health problems

This section discusses factors significantly associated with feelings towards the AFHS Programme's potential to reduce adolescents' health problems, that is, job position, level of education and knowledge of the AFHS programme.

Table 4.13

Contingency Table of the feelings towards the AFHS programme's potential to reduce adolescents' health problems by job position

		What is your job position?							
		Medical Doctor	Registered Nurse	Enrolled Nurse	Radiographic Assistant	Pharmacy Assistant	Community Counsellor	Clerical Assistant	Pharmacy Work Hand
Do you think the AFHS programme will help to reduce these health problems?	Yes	100% (6)	100% (14)	100% (7)	0	100% (1)	60% (3)	0	0
	No	0	0	0	100% (1)	0	40% (2)	100% (3)	100% (1)
Total		100% (6)	100% (14)	100% (7)	100% (1)	100% (1)	100% (5)	100% (3)	100% (1)

Pearson Chi-Square value-30.015[a], df-7, p=0.000

Appreciation of the potential of the AFHS programme to reduce adolescent problems increases with increasing skill levels. Highly skilled personnel could have had many opportunities for both formal and informal training and hence their appreciation of complex issues like adolescent health and the potential the AFHS initiative has. In contrast the lowly skilled staff may either not have knowledge or a deeper understanding of the initiative yet.

Table 4.14

Contingency Table of the feelings towards the AFHS programme's potential to reduce adolescents' health problems by education

		What is the highest level of education that you have completed?	
		Secondary	Tertiary
Do you think the AFHS programme will help to reduce these health problems?	Yes	20% (1)	93.6% (29)
	No	80% (4)	6.4% (2)
Total		100% (5)	100% (31)

Pearson Chi-Square value-16.769[a], df-1, p=0.000

Participants' faith in the AFHS programme to reduce adolescent health problems reduced with decreasing level of education. Just as with highly skilled job position, the highly educated personnel may have a better appreaciation of the programme than the less skilled because of their training, education and exposure (table 4.14).

Table 4.15

Contingency Table of the feelings towards the AFHS programme's potential to reduce adolescents' health problems by knowledge of the programme

		Do you know about the AFHS programme?	
		Yes	No
Do you think the AFHS programme will help to reduce these health problems?	Yes	94.4% (17)	68.4% (13)
	No	5.6% (1)	31.6% (6)
Total		100% (18)	100% (19)

Pearson Chi-Square value-4.081[a], df-1, p=0.043

Participants's faith in the programme's potential to reduce adolescent's health problems increased with their knowledge of the programme. This could mean the programme is viewed as very good and what adolescents need right now and this is so because those who knew about the programme felt it would be helpful to adolescents (table 4.15).

4.3.4 Factors significantly associated with the health workers' supply of contraceptives to adolescents

This section discusses factors significantly associated with the health workers' supply of contraceptives to adolescents, that is, sex, job position, work experience and effective implementation of the AFHS programme.

Table 4.16

Contingency Table on health worker's supply of contraceptives to adolescents by sex

		sex	
		Female	Male
Do you personally give adolescents contraceptives?	Never	30.4% (7)	0
	Sometimes	17.4% (4)	83.3% (10)
	Always	52.2 (12)	16.7% (2)
Total		100% (23)	100% (12)

Pearson Chi-Square value-14.710[a], df-2, p=0.001

While female participants were more likely than males to never have given out contraceptives, they were also more likely to always give them out. Most males were receptive to the idea but inconsistant. This could be because female health workers, although they try to be proffessional, feel they understand the dangers of contraceptives on women than their male counterparts (table 4.16).

Table 4.17

Contingency Table on health worker's supply of contraceptives to adolescents by job position

		What is your job position?							
		Medical Doctor	Registered Nurse	Enrolled Nurse	Radiographic Assistant	Pharmacy Assistant	Community Counsellor	Clerical Assistant	Pharmacy WorkHand
Do you Personally give adolescents contraceptives?	Never	14.3% (1)	13.3% (2)	0	100% (1)	66.7% (2)	50% (4)	50% (1)	0
	Sometimes	71.4% (5)	13.3% (2)	87.5% (7)	0	33.3% (1)	25% (2)	50% (1)	0
	Always	14.3% (1)	73.3% (11)	12.5% (1)	0		25% (2)	0	100% (1)
Total		100% (7)	100% (15)	100% (8)	100% (1)	100% (3)	100% (8)	100% (2)	100(1)

Pearson Chi-Square value -32.349[a], df-14, p=0.004

Less skilled health workers were more likely to never have given contraceptives to adolescents. This could mean the less skilled one is the less undersatnding they have of issues of contraceptives and adolescents. This could also mean less skilled personnel do not believe adolescents should be given or use contraceptives let alone engage in sexual activities (table 4.17).

Table 4.18

Contingency Table on health worker's supply of contraceptives to adolescents by experience

		How many years of experience do you have working in a public health facility?			
		less than 5 years	5 to < 10 years	10 to < 15 years	15 years and above
Do you personally give adolescents contraceptives?	Never	6.7% (1)	37.5% (6)	0	40% (4)
	Sometimes	60% (9)	37.5% (6)	75% (3)	0
	Always	33.3% (5	25% (4)	25% (1)	60% (6)
Total		100% (15)	100% (16)	100%4	100% 10

Pearson Chi-Square value-14.101[a], df-6, p=0.029

The more experienced personnel were more likely to never have given contraceptives. This could be that mature staff believe or actually know contraceptives are not good for adolescents (because of the many years of experience) or they just lack enough training on the issue (table 4.18).

Table 4.19

Contingency Table on health worker's supply of contraceptives to adolescents by effectiveness of programme implementation.

		If you know about the programme, do you think the programme is being effectively implemented?		
		Not at all effective	Not very effective	Somewhat effective
Do you personally give adolescents contraceptives?	Never	0	0	50% (3)
	Sometimes	0	71.4% (5)	0
	Always	100% (4)	28. 6% (2)	50% (3)
Total		100% (4)	100% (7)	100% (6)

Pearson Chi-Square value-15.111[a], df-4, p=0.004

Participants who felt the programme was not at all effective, always handed out contraceptives. Perhaps this is driven by their motivation to make up for the passivity of the group (table 4.19).

4.4 Conclusion

The results indicate while appreciation of adolescent health challenges declines with increasing experience, it increases with increasing education. In the same way, the results reveal appreciation of the AFHS programme's potential to reduce adolescent problems increases with increasing skill levels while this faith in the programme reduced with decreasing level of education. Just like the relationship with contraceptive supply, less skilled health workers were more likely to never have given contraceptives to adolescents the same way participants with more experience were more likely to never have given contraceptives. Again there is no relationship between years of experience and level of education, as is often confussed. These results speak to the need to training and education as it is with the increase of skills and education that understand and knowledge can be achieved. The programme is well appreciated despite concerns of lack of training and proper implementation. Other factors that were found to be associated with its adoption of the intitiative were effective implementation and understanding of the programme and availability of resourses. The conclussions of these findings and recommendations of this study will be found in the next chapter.

CHAPTER FIVE
CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This section presents the conclussions and recommendations of the study on factors associated with the adoption of adolescent friendly sexual and reproductive health service practices by health workers. It also suggests some recommendations for overcoming limitations the study encountered and areas for further study.

5.2 Conclusions

The aim of this study was to establish the reasons why there is a slow adoption and implementation of the adolescent friendly health service practices by health workers in order to improve the adoption thereof and to contribute to the health seeking behaviour of adolescents. The objectives of the study were:

1. To determine the knowledge and understanding of the AFHS programme by health workers at KHC, Namibia.
2. To establish the factors that are associated with the slow adoption of adolescent friendly health practises by health workers at KHC, Namibia.
3. To evaluate the approach that the MoHSS is using to introduce and implement the AFHS programme to the health workers.
4. To recommend better approaches to introducing new programmes to health workers and to provide guidelines for interventions that increase the uptake of AFHS at public health institutions in Namibia.

5.2.1 Health worker's knowledge and understanding of the AFHS programme

While the Government should be commended for its efforts on AFHS provision through building the capacity of health workers, the results of the study are unfortunately indicating the AFHS programme is not yet doing as well as expected. It is distressing this similar finding was reported 7 years ago (a rapid assessment on AFHS). At the study site, KHC, the biggest referal clinics in Khomas region, the majority of the respondents (41%) confirmed the programme is not being effectively implemented. This is not surprising considering very few health workers are knowledgeable and have a clear understanding of the programme; how it should be implemented. Health workers are key in the adoption of AFHS so priority should be given to ensuring the understand the programme, its requirements and their important role. The minimum package for AFHS, Counceling and Education, clinical services and referrals need to be known

to health workers for adolescents to benefit from them. Although the study revealed very few adolescents visit the facility, these should get a comprehensive package in an adolescent friendly manner, as this on its own can help in improving their health seeking behaviour. There, however, seem to be an inclination to clinical services.

5.2.2 Factors associated with the adoption of the AFHS by health workers

Factors significantly associated with the adoption of AFHS by health care workers were: sex, level of education, job position, work experience, know of AFHS and effective implementation of the programme. Study results indicated: while female participants were more likely than males to never have given out contraceptives, they were also more likely to always give them out. Results also showed most males were receptive to the idea but were inconsistant. This indicates a need to continue educating both female and male health workers (with special consideration of their socio-cultural differences) on the important role contraceptives can play in reducing many of the adolescent health problems.

The level of education and job position indicated the study found out that: Appreaciation of adolescent's health problems was found to positively correlate with increasing education; participants' faith in the AFHS programme's capacity to reduce adolescent health problems reduced with decreasing level of education; faith in the AFHS programme's potential to reduce adolescent problems increases with increasing skill levels and lastly, less skilled health workers were more likely to never have given contraceptives to adolescents. These are combinely discussed because of the link between level of education and job positions. All the findings demonstrate health workers with tertiary education or in high skilled positions understand both the adolescent health challenges; the usefulness of AFHS in reducing these challenges and the the importance of contraceptives better than those with secondary education or in low skilled job positions. This has implications for training, where more effort is needed in training (on adolescent health, AFHS and contraceptive use by adolescents) the health workers with low levels of education and in low skilled job positions.

The following findings relate to work experience; (appreciation of adolescent health challenges declines with increasing experience and the more experienced personnel were more likely to never have given contraceptives) show how work experience is significantly associated with adoption of AFHS. The more experienced health workers do not appreciate or understand that adolescents face SRH challenges and these will most likely not adopt AFHS. The same also do not agree with giving contraceptives to adolescents and will not adopt this component of AFHS. Participants's faith in the programme's potential

to reduce adolescent's health problems increased with their knowledge of the programme; those who know about the programe will adopt it.

One factor that was anticipated would be significantly associated with adoption of AFHS but was not, it was rather the variable age. It was interesting to note while work experience was significantly associated with adoption, age of health worker was not, although the more the years of experience the older one is. How does it happen that someone with over 15 years of experience, for example, never gives contraceptives, while someone 50 years and above does?

5.2.3 How the programme was introduced (government approach)

Study results, both quantitative and qualitative data, indicate the way the programme was introduced leaves a lot to be desired. The feelings of exclusion in the development of the AFHS could have been avoided by ensuring they have more information on the processes, from who was representing them and how. Respondents complained about lack of feedback, supervision and monitoring and evaluation visits and in as much as this should be done at facility level, higher offices should constantly support at least in these early phases of inception. It was evident most health workers do not know whether their facility has started implementing AFHS this indicates a challenge in the way the programme was intorduced and this affects adoption. Counselling and Education is key in AFHS as it is part of the minimum package for every health facility and this component is defined by the availability of IEC materials. These are reported by most health workers (58%) to never be available in consulting rooms with some adding the facility does not even have an AFHS sign or poster that its being implemented or available; a very unfortunate situation considering the importance and potential this programme has.

While the Government is training service providers on how to handle adolescents, this training should be more specific on the importance of the intervention and how exactly the health workers should treat adolescents. There is a general shortage of staff, infrastructure and space makes one wonder how the short and long term plans were from the initial planning.In the national standards for AFHS, Government acknowledges the need for space and infrustructure for the environment to be attractive and friendly to adolescents (MoHSS, 2011), however, it continues to state, 'this is can be done by creating a new or modifying the existing infrastructure depending on availability of resources'. It is the Government that has to avail those resources; human, financial and physical and for the sake of adolescents, development and the nation, the earlier this is done, the better. The opportunity here is some of the health workers

showed inthusiasm and are motivated to implement AFHS and this is an opportunity as this could actually benefit the adolescents.

5.3 Recommendations

This section presents some suggestions on how the problem the under study could be solved. These are policy and implementation recommendations and areas for further study.

5.3.1 Implementation gaps

There is need to use strategic approaches to promote adolescent health to health workers, adolescents themselves, their parents/ guardians and teachers and the community:

- Through increasing awareness and appreciation of adolescent diverse challenges and needs
- Now that the AFHS initiative has been introduced, its implementation needs strengtherning and to be hastened. This will call for government to take a leading role in monitoring the progress thus far and to address all the challenges the programme is facing in a more participatory and holistic manner.
- There is need for dissemination of AFHS national standards and IEC materials. These are important tools for health workers without them is like going to war without guns.

5.3.2 Training and development:

Adoption of AFHS may not be entirely successiful without proper training and education on adolescent health hence the need to really take a closer look at this area:

- AFHS may be added (meanifully) to health worker pre-service training such that after they qualify, they are already oriented and then comprehensive training done only with those working directly with adolescents.
- AFHS may also be added as an area of specialty; after health workers qualify, they then add another 3 or so months specialising in adolescent health.
- The above suggestions may not entirely eradicate the problem, but will help with sustainability and ease the problem of staff turnover and cost and time that comes with training/ refreshers/ orientations happenning now.

5.3.3 Infrastructure and Space

Without space (whether a room/ private corner or separate building), the service may never be adolescent friendly as many other issues revolve around this:

- Privacy
- Confidentiality
- Adolescent participation,
- Staff motivation
- Stigma
- Judgement

5.3.4 Areas for further study

The following is recommended:

- With this whole controversy around contraceptives and adolescents; it would be interesting to find out if health workers are emphacising dual protection and which combinations and how adolescents themselves feel about dual protection. The same with emergency contraception.
- It would also be important to find out if religion is associated with adoption of AFHS by health workers and what recommendations the government can get from the study findings.

5.4 Study Limitations and Recommendations

Time constraints were a major factor in conducting this research. This was because of the delays the researcher experienced in getting ethical approval from MoHSS. While it is important for this ethical approval process to be done, the ministry may want to consider reducing the period to a month or less. This will allow researchers to have more stime for data collection, analysis, interpretation and help with production of quality products. The research commettee should, however, be commended for a thorough and proffessional service they delivered. MoHSS may, however, also want to educate health workers on the importance of research to the country as some few of them do not seem to understand how others benefit from these researches.

5.5 Conclusion

There are a number of factors that are significantly associated with adoption of AFHS and these are sex, level of education, job position, work experience, know of AFHS and effective implementation of the programme. The system is in place, so is the workforce with the right attitude, what is left is to tighten some loose ends and programme is up and running. It is hoped the study findings and recommendations will help strengthern the fight against the HIV epidemic in general and AFHS in particular.

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ANNEXURE

ANNEX 1: QUESTIONNAIRE

HEALTH SERVICE PROVIDER QUESTIONNAIRE

Name of researcher: Mrs Rejoice Chakare from Stellenbosch University

Name of Facility and where its located:	Katutura Health Centre (KHC), Khomas Region, Namibia
Type of Facility	1. Primary
Type of data collection method	**1.** Self-administered questionnaire **2.** Face to face Interview on questionnaire **3.** Telephone interview on questionnaire

Objectives:

The aim of this study is to establish the reasons why there is a slow adoption and implementation of the adolescent friendly health service (AFHS) practices by health wor`kers in order to improve the adoption thereof and to contribute to the health seeking behaviour of adolescents. The study also aims to provide guidelines for interventions that improve the uptake of the AFHS. The objectives will be to establish the factors that are associated with the slow adoption of adolescent friendly health practises by health workers at KHC, to establish the approach that the MOHSS is using to introduce and implement the AFHS programme to the health workers, to recommend better approaches to introducing new programmes to health workers and to provide guidelines for interventions that increase the uptake of AFHS at public health institutions in Namibia. The study will also help provide insight into implementation of policies programmes and cross-cutting issues (capacity gaps, opportunities and best practices – what is working).

Participants:

The participants of this study will be the facility level staff: Nurses, doctors, community counsellors, pharmacists, radiographers and front office clerks.

Data collection methods;

The researcher will provide this questionnaire to all participants and they administer themselves. If preferred, the researcher will ask the respondents (the same questions) and record the responses. In other unique situations telephone interviews on questionnaire will be carried. The researcher is asking for your assistance in providing your views on the adolescent friendly health service intervention, its implementation at your facility and the successes and challenges thereof. The findings will help improve the programme, help other facilities from lessons learnt and success stories.

Thank you for agreeing to participate in this study and for taking your time to fill in this questionnaire. Participation in this assessment is voluntary, and you can choose not to answer any individual question or all of the questions. However, I hope that you will actively participate since your views are important. Your responses are very confidential and private; no one person will be able to link the results to you. So please feel comfortable to write/speak freely.

{The questions are coded on the left side of the response}

Questionnaire ID……..Today's date……

Date of Birth (DD/MM/YYYY)……Sex (circle): 1. Female 2. Male

Did you complete the Consent forms? (Circle): 1. Yes 2. No

NB:

1. **Please circle the correct answer wherever you are given a multiple choice.**
2. **In this questionnaire, adolescents are people aged 10-19 years.**

DEMOGRAPHIC & SOCIO-ECONOMIC CHARACTERISTICS

1. **What is your job position?** 1. Registered Nurse (RN) 2. Enrolled Nurse (EN) 3. Medical Doctor 4. Community counsellor 5. Pharmacist 6. Pharmacy Assistant 7. Radiographic Assistant 8.Clerk 9. Clerical Assistant

2. **How many years of experience do you have working in a public health facility?**
   1. Less than five years. 2. Five to less than ten years. 3. Ten to less than 15 years 4. 15 years and above

3. **What is your first language (mother tongue)?** 1. Oshiwambo 2. Otjiherero 3. Khoekhoegowab 4. Lozi 5. Rukwangali 6. Afrikaans 7. Other (specify)……

4. **What is the highest level of education that you have completed?** 1. Primary school 2. Secondary school 3. Tertiary school 4.Other……..

ADOLESCENT FRIENDLY HEALTH SERVICES PROGRAMME

5. Do you know about the AFHS programme? 1. Yes 2. No

6. If yes, what is it about? If no, please skip to question 17.

7. Were you trained in AFHS? 1. Yes 2. No

8. If not, do you know of any health workers that were trained at Katutura Health Centre (KHC)?

1. Yes 2. No

9. If you know about the AFHS programme, how do you feel about it (the package)?

10. Do you think the programme was introduced to you properly?

1. Yes 2. No

11. Please explain your answer

12. If you know about the programme, do you think the programme is being effectively implemented?

1. Not at all effective 2. Not very effective. 3. Somewhat effective. 4. Very effective

13. Please tick one response for each of the following items:

Response / Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The programme rollout has not yet started					
2. The programme has started but there is no facility space for effective implementation					
3. The programme is running but adolescents are not coming because of the health worker reputation					
4. The health workers do not agree with the issue of tolerating with adolescent sexual activities					
5. The attitudes of health workers towards adolescents are preventing effective implementation of the programme					
6. The health workers are not friendly to adolescents who require HIV and SRHR information					
7. Not all health workers were trained on AFHS and therefore adolescents face challenges in some instances					
8. The package is asking for too much and health workers don't really have the time to follow it wholly					

9. Health workers judge adolescents who present with STIs and this is one of the reasons why participation is low					
10. When adolescents visit health facilities they want to be given health related advice and IEC materials but this is not happening.					

14. What is required for the programme to be effectively implemented?

15. What is your role in the effective implementation of the AFHS programme?

16. If you were to suggest to government better ways of introducing programmes to health workers, what would you say?

ADOLESCENT HEALTH

17. Do you think adolescents face a lot of HIV and sexual and reproductive health problems?

1. Yes 2. No

18. If yes please state the health problems adolescents face

19. Do you think the AFHS programme will help to reduce these health problems?

1. Yes 2.No

20. If yes, in what way will it help?

21. Do you think adolescents need specialised programmes like the AFHS programme for their health to improve?

1. Yes 2. No

22. Please circle the programmes you think are most important for adolescents:

1. Contraceptives methods including condoms
2. Counselling and education
3. STI screening including HIV and management
4. Health IEC materials
5. Health education on abstinence, gender equality and nutrition

ADOLESCENT FRIENDLY ENVIRONMENT

23. May you please indicate what age group is the nurse currently responsible for dealing with adolescents?

1. Less than 20 years 2. Between 20 and 29 3. Between 30 and 39 4. Between 40 and 49 5. 50 years and above 6. There is no one allocated to adolescents

24. Is the location of your adolescent consulting room convenient and accessible?

1. Yes 2.No 3. There is no consulting room for adolescents

25. Does your facility's consulting room for adolescents ensure privacy and no one can over hear the health worker/ adolescent conversations?

1. Yes 2. No

26. Are adolescent friendly information education and communication (IEC) materials available in the adolescent consulting rooms?

1. Never available 2. Not often 3. Sometimes 4. More often

27. What do you think should be done to improve space, privacy and confidentiality in the facility?

1. Space

2. Privacy

3. Confidentiality

(*adapted from NEDICO 2005)

CONTRACEPTIVE USE AND FAMILY PLANNING

*** In this section, please answer all questions that are applicable to your job.**

28. Do you think adolescents should be given contraceptives to protect unwanted pregnancies and STIs including HIV? 1. Yes 2. No

29. Please motivate (explain) your answer to the above question

30. Do you personally give adolescents contraceptives?

1. Never 2. Sometimes. 3. Always

31. Do you personally offer condoms to adolescents?

1. Yes 2. No

32. Circle all contraceptive types that you think are best for adolescents?

1. Condoms 2. IUD 3. Contraceptive Patch 4. Contraceptive Injection
5. Contraceptive Implant 6. Oral contraceptive 7. Surgical sterilisation 8. Withdrawal
9. Rhythm method

33. Does your facility have all the types of contraceptives available?

1. Yes 2. No 3. I don't know

34. Does your facility offer all the types of contraceptives they have available to adolescents 1. Yes
2. No 3. I don't know

35. What do you think about the use of family planning by adolescents?

1. Strongly Disapprove 2. Disapprove 3. Neutral 4.Approve 5.Strongly Approve

36. Are family planning services available for all at your health facility?

1. Yes 2. No 3. I don't know

37. Briefly explain your answer

38. Please tick one response for each of the following items:

Response **Statement**	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Contraceptives are not good for the health of adolescent girls and therefore should not be given.					
2. Providing contraceptives to adolescents encourages promiscuity.					
3. Adolescents do not need parental/guardian/spousal approval to use or not use contraceptives but can make their own decisions.					
4. When possible health workers should notify parents/guardians if an adolescent collects a condom, requests for contraceptives, is pregnant, has an STI or any of their sexual activities.					
5. Adolescents should be given all the information about the dangers of contraceptive use.					
6. Adolescents should be given all the					

information about the dangers of early sexual debut.					
7. Condoms prevent STIs including HIV and unwanted teenage pregnancies so they should be available to them.					
8. Health workers are not comfortable giving adolescent girls certain types of contraceptives					
9. Adolescent parents are not getting the services meant for adolescents					
10. IEC for contraceptive methods are not always available					

Thank you for providing this important information. Do you have any comments or questions?

What happens next? After all the participants have filled in their questionnaires, I will collate all the information; write a report to be submitted to MOHSS. I will also call you for a de-briefing meeting where I will present the findings to you.

ANNEX 2: INFORMED CONSENT

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Attitudes towards adolescent friendly health service provision among health workers at a primary health care clinic in Windhoek, Namibia

Health Workers

You are asked to participate in a research study conducted by Rejoice Chakare (Bsc Honours in Sociology; Post Graduate Dip in HIV management; Diploma in Human Resources) from the Africa Centre for HIV Management at Stellenbosch University. The results of the study will contribute to the thesis of the researcher. You were selected as a participant in this study because you are a health worker at Katutura Health Centre (KHC). This institution was selected because it is one of the few institutions that has health workers trained in adolescent friendly health services and has started implementing the programme.

1. PURPOSE OF THE STUDY

The purpose of the study is to help understand the adolescent friendly health service programme and its implementation, including challenges encountered. The study will also provide recommendations for better ways of working with the youth. It will also help to recommend better approaches to introducing new programmes to health workers and to provide guidelines for interventions that increase the uptake of AFHS at public health institutions in Namibia.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

2.1 The questionnaire

The researcher will give you a self-administered questionnaire or alternatively the researcher will record your responses in an interview. Some interviews may also be conducted telephonically.

2.2 Time

Filling in the questionnaire or the interview will take about 45 minutes to an hour and it will be done once. You will also be invited to a debriefing meeting when the results are out and this meeting will be within an hour. The total time will therefore be within two hours.

2.3 Location of the meeting

If you choose not to fill in the questionnaire yourself, the researcher will make an appointment to come and meet with you when you are at work; so the meeting place will be KHC.

3. POTENTIAL RISKS AND DISCOMFORTS

I do not think this study will cause any physical or psychological risks. If you are not comfortable answering any specific questions you may choose to skip them. Information will be recorded without any identifying details and handled confidentially

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

This study may have a number of benefits The MOHSS may better understand the factors that assist or hinder the adoption of AFHS through the sharing of the findings. It will also help them to develop better approaches to introducing to health workers new initiatives like the AFHS programmes to understand how the health workers feel about the AFHS initiative and how to have them implement the programme well.

5. PAYMENT FOR PARTICIPATION

The respondents will not receive any form of monitory payment. However if face to face interviews are held, refreshments will be provided. This is the same for the inception or de-briefing meetings. If the respondents have to travel to the interviews and the debriefing meeting, then transport reimbursements will be given.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of safeguarding the data received from respondents. The responses will be recorded with accuracy and once the data is all gathered, a report will be produced and findings shared findings with participants in a debriefing meeting in the presence of KHC management. The MOHSS as the mother institution, responsible from AFHS will also receive a report of the findings. The interviews will not be be tape-recorded or videotaped. Once a debreifing meeting is held and permission sought to publish the results then the study will be put on the Stellenbosch website for cross-learning. The data will be securely stored on the researcher's computer which is protected with a secure password. No other person will have access to the respondent information. This data will also be disposed within a period of 3 years.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. These circumstances may include failure to respond to the questionnaire or failure to be available for an interview within the timeframe provided and for any reason. This is so because this is an academic study and the researcher has a limited time frame to finish the study. A professional relationship should be maintained between the researcher and the respondent failure of which may results in the withdrawal of the relationship.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact the Principal Investigator, Ms. Rejoice Chakare on cellphone +264 814 059396 and +264 8007604. Email rchakare@gmail.com. Ms. Chakare stays at ERF892 Nauchab Street, Cimbebasia, Windhoek, Namibia.

Or

The Supervisor of this study, Professor Elza Thomson on cellphone +27…. and +27...
Email elzathomson@gmail.com.

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me by Rejoice Chakare in English and I am in command of this language or it was satisfactorily translated to me. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____
Name of Participant

_____ _____
Signature of Participant **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____. [He/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in English and no translator was used.

_____ _____ _____
Signature of Investigator **Date**

ANNEX 3: PERMISSION TO STUDY

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198 **Ministerial Building** **Tel: (061) 2032626**
Windhoek **Harvey Street** **Fax: (061) 222558**
Namibia **Windhoek** **E-mail:** tkakili@yahoo.com

Enquiries: Ms. T. Kakili **Ref:** 17/3/3 **Date:** 22 October 2012

OFFICE OF THE PERMANENT SECRETARY

Ms Rejoice Chakare
P.O.BOX 98471
Pelican Square
Windhoek

Dear Ms Chakare

Re: Attitude towards Adolescent Friendly Health Services provision among health workers at Primary Health Care Clinic. .

1. Reference is made to your application to conduct the above-mentioned study.

2. The proposal has been evaluated and found to have merit.

3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for completion of your Master of Philosophy degree in HIV Management;
3.2 No other data should be collected other than the data stated in the proposal;
3.3 A quarterly report to be submitted to the Ministry's Research Unit;
3.4 Preliminary findings to be submitted upon completion of study;
3.5 Final report to be submitted upon completion of the study;
3.6 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,

MR. ANDREW NDISHISHI
PERMANENT SECRETARY

"Health for All"